PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 6/9/16

Auditor Information			
Auditor name: Bridgette M. Collins			
Address: 8933 Caminito Rd, Indianapolis, In 46234			
Email: confinementsafety@gmail.com			
Telephone number: 317 679 0879			
Date of facility visit: 5/11/16			
Facility Information			
Facility name: Hope Hall			
Facility physical address: 811 E. Franklin St, Evansville, In 47711			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 317 686 9779			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☒ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Bob DeCarli			
Number of staff assigned to the facility in the last 12 months: 22			
Designed facility capacity: 100			
Current population of facility: 58			
Facility security levels/inmate custody levels: minimum			
Age range of the population: 22-73			
Name of PREA Compliance Manager: Shannon Schumacher		**Title:** Chief Operating Officer	
Email address: sschumacher@voain.org		**Telephone number:** 317 686 9779	
Agency Information			
Name of agency: Volunteers of America			
Governing authority or parent agency: *(if applicable)* Volunteers of America			
Physical address: 927 N. Pennsylvania St., Indianapolis, In 46204			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 317 686 9779			
Agency Chief Executive Officer			
Name: John Von Arx		**Title:** Chief Executive Officer	
Email address: jvonarx@voain.org		**Telephone number:** 317 686 5809	
Agency-Wide PREA Coordinator			
Name: Shannon Schumacher		**Title:** Chief Operating Officer	
Email address: sschumacher@voain.org		**Telephone number:** 317 686 9779	

AUDIT FINDINGS

NARRATIVE

The Mission of Volunteers of America of Indiana is a faith-based organization that provides life-changing services to enhance the physical, emotional, spiritual, and intellectual needs of individuals by providing counseling, rehabilitation, job placement, and residential services. They serve individuals transitioning from the correctional system, the elderly, the developmentally disabled, chronically addicted and mentally ill.

At least 2 weeks prior to the on-site audit, flyers were hung with contact information for the Auditor in the event staff or residents wanted to send anonymous materials through the mail. No documentation was received by the Auditor from staff or residents prior to, during or after the audit.

On 5/11/16, an on-site audit was conducted on Hope Hall, a facility governed by Volunteers of America located in Evansville, Indiana. The facility is a co-ed work release program that services the local courts, the Indiana Department of Correction as well as the Federal Bureau of Prisons.

The facility has a bed capacity of 82 males and 18 females. On the day of the audit, the total population was 58 (50 males and 8 females). There are currently 22 staff employed including both custody and treatment positions for the operation of the facility 24 hours per day/7 days per week.

Eight interviews of residents were conducted equally distributed by gender. Selection of residents included finding persons of different sentencing authorities, ages, race, level of charges and length of time in the facility. All of them had previous incarceration at a different facility prior to their arrival to Hope Hall. Interviews are voluntary and not mandatory, all selected persons agreed to speak with the Auditor with no reservations. None of the residents interviewed identified as belonging to the LBGTI (lesbian, bi-sexual, gay, transgender or inter-sex) population.

The residents readily admitted that they knew of PREA standards because it had been presented at intake and was visible on flyers throughout the facility but didn't know intricate details because they weren't concerned for their safety. They felt that the institution is operated in a manner that their safety is a priority.

Facility specific staff were also interviewed including the Facility Head (1), Line Supervisor (1), Correctional Officers (5) and Case Manager (1). Because custodial positions are a 24 hour operation, interviews were conducted on staff of different shifts/rotations to ensure that all are knowledgible of operations in the absence of administrative staff after-hours. The results of the interviews confirmed that they staff feel they are employed in a safe working environment and that the agencies zero-tolerance policy would be followed in the event of a PREA related incident.

All staff were able to provide feedback on the different ways for staff or residents to report abuse and the process thereafter. Staff was aware that investigations of criminal nature are to be conducted by law enforcement but will still need to be reported to the agencies PREA Coordinator. They understood the method for securing the victim and preservation of evidence if available.

On 5/12/16, an on-site audit of the Human Resources office for Volunteers of America was conducted. The agency governs facilities in all Indiana counties except for Floyd and Clark. Main program offices are located in Evansville, Fort Wayne, Gary, Indianapolis and Terre Haute. Volunteers of America of Indiana has 25 distinct programs including behavioral health supports, reentry services, veterans and veteran family programs, senior housing and adults with developmental disabilities.

During the audit of employee files, an interview of Human Resources was conducted. There was discussion about some of the obstacles with maintaining PREA compliance in areas wherein those served are not inmates. Some suggestions were provided on how to be compliant without jeopardizing contracts with other outside organizations.

All materials presented were well organized, signed and dated. The information was easily accessible and specific to the employee.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility is a one story building among warehouses in the nearby area. There are three housing dormitories, two for males and one for females. Each dorm has its own separate shower/toilet facilities as well as laundry rooms. The control area of the facility is located at the entrance and is equipped with restroom faculties for the staff. This is where cameras are monitored and all movement in and out of the facility is documented for both staff and residents. There are nine offices occupied by Administrative staff. There is a kitchen for dining and multiple storage spaces throughout. There is a conference room for meetings as well. The facility is located on a bus line for daily transportation.

SUMMARY OF AUDIT FINDINGS

Hope Hall was well prepared for the audit. All pre-audit information was received by the Auditor in a timely manner. The PREA Coordinator provided labelled supportive documentation that was easily reviewed for compliance.

The facility and its grounds were clean and well maintained. Both staff and residents of the facility have a positive outlook on the facility, its operations and the upper level management. Each resident and staff that were interviewed admitted that they felt safe in that environment and felt that if in the event of a PREA incident, that it would be addressed correctly per policy.

During the on-site portion of the audit, there was some minor updates that were cause for concern but were easily corrected. The laundry rooms of each dormitory had solid wooden doors and remain closed even while in use. A discussion with the facility head and PREA Coordinator determined that putting a glass pane for easy viewing in the door would aid in visual acuity when doing rounds by custodial staff. There corrections were completed within the 30 period prior to needing a corrective action period.

Hope Hall has met the standards for the PREA audit.

Number of standards exceeded: 0

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Volunteers of America have had the PREA (Prison Rape Elimination Act) policy in place since 6/10/13 and is listed as COR 5.3-40. It was revised in September of 2014 and was most recently approved on 01/13/15. This policy includes 34 pages of expectations and procedural direction in maintaining compliance with the PREA standards. The policy specifically states that the agency has a zero tolerance towards all forms of sexual abuse and harassment within directly supervised facilities as well as those operated under contract. The policy outlines the expected implementation for prevention, detection and response to sexual abuse and harassment. Sexual abuse and harassment are clearly defined in the policy as well as the potential sanctions upon substantiated findings. The definitions include that these expectations are not only to be met by the residents, but staff, contractors and volunteers as well. The policy includes a prevention plan, training/education, responsive plan and screening for risk of sexual victimization and abusiveness.

Multiple levels of staff were interviewed regarding the PREA policy and their specific responsibilities in the event they are a first responder to allegations being made. Each person could identify the chain of command, their responsibilities as a staff and how to maintain the safety and security of the institution and all remaining residents and staff.

There is an agency-wide PREA Coordinator who is responsible for conducting initial investigations on sexual harassment to determine whether or not law enforcement should be involved. If the case presented is obvious sexual abuse, law enforcement are immediately contacted with notifications to the PREA Coordinator as well.

Through interviews with the PREA Coordinator, it was accessed that she feels she has enough time to conduct all the necessary steps for maintaining compliance with the standards, as presented to the facilities in which she must monitor. All necessary documentation was readily accessible and organized when requested by the Auditor during the course of the on-site visits as well as the pre-audit phase. The PREA Coordinator was present at each of the three facilities that received an on-site visit during the audit.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Hope Hall hasn't entered into a contract for the confinement of residents since 8/20/12. This standard is not applicable.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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In 2016, an annual review of the facility staffing plan for 2015 was conducted as is required per policy. Based on the Federal Bureau of Prisons Statement of Work, there must be one male and one female correctional officer on duty at all times and this is achieved daily in the control area for video equipment monitoring. There were no PREA allegations or staffing plan deviations in 2015, 2014, 2013 and 2012. In December, 2014, there was no staffing plan deviation, however there was one unsubstantiated PREA allegation between 2 residents.

On the day of the audit, both genders of staff were readily available for interviews and resident monitoring. The average daily number of residents since 8/20/12 has been 71 and the staffing plan is predicated for an average daily population of 68.

Currently there are 2 full time staff (one male/one female) assigned to each of the three shifts Monday through Friday (6a-2p, 2p-10p and 10p-6a). There are 2 part time staff (one male/one female) assigned to each of the two weekend shifts for Saturday and Sunday (6a-6p and 6p-6a). There is also staff whose primary purpose is to work wherever is needed but usually works Monday through Friday from 2p-10p.

The Facility Director requests allocations to improve visibility of residents in their day to day routines without the need to hire more staff. This includes requesting additional cameras and other equipment such as mirrors and windows.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency doesn't allow for cross-gender strip or gross-gender visual body cavity searches of residents as written in policy. Residents are never to be in a state of undress in front of any staff and are protected by policy to limit viewing while performing daily self care and grooming except for incidental situations occurring while doing routine visual checks, including camera viewing. Residents are required to only be in a state of undress in the restrooms and not in the common areas. Staff of the opposite sex announce themselves before entering the dormitory area.

Residents are not denied access to regularly available programming because there is always a same-sex staff member on duty. PREA Policy specifically states that staff are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the residents genital status.

Interview of residents support that policy is being followed as written. There were no reports of ever being in a state of undress in the presence of any staff. Staff interviews proved to also provide feedback that they are to announce themselves if of opposite gender before entering dormitory areas and that they are never to enter into the restrooms while they are in use.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy COR 5.3-40 specifically outlines established procedures to provide equal opportunity for disabled residents as well as residents with limited English proficiency to participate in and benefit from all aspects of the Agency's efforts to be PREA compliant.

While there have been no residents assigned to the facility with limited English Proficiency, there are bilingual (Spanish) flyers hung throughout the facility for informational purposes. The Facility Director is aware of demographic information regarding incoming residents prior to their arrival. In the event that an interpreter is needed to relay pertinent information, there is access to an outside agency to provide those services through the organization. Resident interpreters would only be used in limited circumstances where an extended delay could compromise the residents safety, the performance of the first-responders duties and or the investigation of a residents allegations.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Volunteers of America Policy 3-30 entitled Hiring Employees addresses PREA compliance with ensuring that reference and background checks are completed prior to the hiring process.

Policy 3-34 entitled Criminal Background Check states that all new employees and volunteers must undergo a criminal records check as dictated according to the program and department with re-checks to be completed by HR as necessary. Falsification of information may result in termination from employment. Criminal history and background checks are completed annually or as necessary after employment.

Policy COR 5.3-40 states that no employees hired or promoted as well as contractors may have contact with a resident who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility or other institution. If there has been a conviction of any sort whether civil/criminal or administratively adjudicated, they shall not be hired or promoted. Any incidents of sexual harrassment shall be considered when determining to hire or promote anyone or enlisting the services of any contractor who will have access to the residents. Best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an allegation of sexual abuse is required.

Background checks will be conducted at least every 5 years for current employees and contractors. All applicants and employees who will have access to residents will be asked about any previous misconduct during the interview process. Material omissions or false information shall be grounds for termination.

Interviews of the Human Resource Manager and documentation found in employee files support that these policies are being followed as intended. A sample of 6 employee files were reviewed including new and veteran staff. Dated written proof was visible in all files that criminal background checks were being done and that PREA compliance is addressed prior to being hired.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has not acquired new video monitoring systems, electronic surveillance or monitoring technology since 8/20/12. There have not been any expansions or modifications to the existing facility either.

The Facility Director shared that getting more cameras in the dormitory areas is on his agenda when funding becomes available. He realizes that an increase in visual monitoring will help in more areas than just PREA concerns.

The staffing plan addresses the purchase of technological equipment along with actual staff for monitoring. The review that is conducted following a potential PREA event will also include the need to increase safety and security of the institution if it took place in an area not as well monitored as the agency would like.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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If there is a PREA incident that involves criminal sexual abuse, all investigations are conducted by the law enforcement within the community. The PREA Coordinator is made aware and will complete whatever paperwork is necessary for Human Resources but that would be the extent of her responsibilities in these types of cases.

Staff have all been trained on the proper procedures to follow after being made aware of a PREA incident that includes sexual abuse whether it be on a staff or a resident. Police Dispatch would be called and law enforcement would handle everything from that point forward.

Victims can receive medical care at Deaconess Health System through the SANE (sexual assault nurse examiner) program, free of charge. There are nursing staff who have received specific training on the forensic medical examinations, evidence collection, preserving the victims dignity and getting referrals to community support services.

Albion Fellows Bacon Center has a Sexual Assault Program that works with victims following the trauma. They provide free comprehensive services that include24-Hour Advocacy, Crisis Counseling, Information and Referral, Support GroupsLegal Advocacy, Community Education and Awareness Events.

Memorandums of Understanding were attempted to be put in place between Hope Hall and both Deaconess Health and Albion but were not completed by the time of this audit. There was some concern on the part of the Community partners regarding the wording and legalities of

the document. The Facility Director is working diligently to find out what needs to be changed to make the document more acceptable and perhaps gain the necessary signatures. In the meantime, the absence of an MOU doesn't hinder the use of these facilities for PREA incidents.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy COR 5.3-40 states that administrative or criminal investigations are completed for allegations of sexual abuse and harassment including both residents and staff. The policy also states that all allegations will be referred to law enforcement for a complete and thorough investigation. The Agency requires written documentation of any referrals to outside agencies for investigation. If the allegation doesn't involve potentially criminal behavior, the investigation is conducted by the PREA Coordinator. The findings of the internal investigation are provided in written form to Human Resources and/or the Facility Director depending on who is involved in the situation.

Volunteers of America website provides information on the zero tolerance policy. Also contact information for ways the public can make a PREA report can be found on the website. This includes both a phone number and email address for the PREA Coordinator.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Per Policy COR 5.3-40, all staff are trained in PREA upon hire and annually thereafter for refresher. The training includes:
*recognition of signs of sexual abuse/misconduct;
*fulfillment of responsibility on preventing, detecting;
* reporting and responding to sexual abuse/harassment;
*ways for residents to report incidents;
*staff and residents right to be free from retaliation;
*dynamics of sexual abuse/harassment victims;
*common reactions of sexual abuse, crisis intervention, and treatment;
*crime scene and evidence preservation techniques;
*avoiding inappropriate relationships with residents;
*effective communication with residents;
*compliance with relevant laws for mandatory reporting;
*cultural competency regarding the LGBTI community (lesbian, gay, bi-sexual, transgendered and intersex or gender nonconforming); and,
*duties of first responders.

Copies of signature sheets of completed PREA training were provided for Hope Hall employees. All 20 current employees have been properly trained on PREA within the last calendar year.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Copies of signature sheets for PREA training for both contractual employees as well as volunteers were provided by the facility. They are provided a brochure that has all the pertinent information for them as a resource due to not being actual employees of Volunteers of America. Training is provided to contractual employees and volunteers on an annual basis as well.

All 5 current volunteers/contractors have been properly trained on PREA within the last calendar year.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Policy COR 5.3-40 outlines the expectation for training and education of the residents concerning PREA. It states that during orientation, the residents will be provided information both orally and in written format regarding the zero tolerance policy, prevention/intervention, self-protection, reporting abuse, freedom from retaliation and Volunteers of America's response to alleged incidents. Residents are provided a brochure, flyers are hung throughout the facility on ways to report and information can be found in their handbook. Some materials are available in Spanish.

Orientation is completed on all new intakes within 72 hours of arrival. The agency is committed to ensuring that residents will be made aware even if they are limited in English proficiency, visually impaired, limited literacy or any other disability.

A total of 8 residents were interviewed and asked specific information regarding both the orientation timeline and what was presented. All of them were able to verify that orientation was completed within 72 hours of arrival and that they were given information about PREA and reporting. They also know of multiple sources they can use to get information to contact an outside agency for assistance.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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All criminal investigations are completed by law enforcement not facility staff. The police departments are responsible for ensuring proper training for their employees.

This standard is not applicable.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Hope Hall doesn't have medical staff who regularly work within the facility, however they do have mental health clinicians. There are currently 2 employees and both have been properly trained on PREA and signature sheets were provided. Because the mental health clinicians are considered employees, they are mandated to completed the required training of all new hires.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy COR 5.3-40 states that within 72 hours of admission, staff will conduct an assessment through interviews and a review of the residents record to attempt to determine the potential to be a sexual aggressor or sexual assault victim. It also states that within 30 days following arrival, a reassessment shall be conducted to ensure that the residents status hasn't changed since intake.

Hope Hall uses a PREA screening tool that is found in their Secure Management Software. Upon completion of the objective screening instrument, the staff has the ability to enter specific notes that support the findings based on resident behavior and past experiences etc. At the 30 day mark or following an event, the resident is met with by their case manager to complete a reassessment. Notations are then made

in the software to document proof of the event.

Depending on the persons risk, they are strategically assigned bedding areas based on availability. There is an attempt to place them directly in the view of cameras or where easily visually monitored upon entering the dormitory areas. They are not housed based on potential aggressor vs victim. Also their PREA risk will increase the frequency of meetings with their case maanger for precautionary measures.

The PREA policy states that residents are not disciplined for refusing to answer or disclose information regarding their mental, physical or developmental disabilities, perception of being a part of the LBGTI community, previous sexual victimization or the perception of their own vulnerability.

All interviews conducted on residents and staff support that policy is being carried out by staff within the facility.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The risk screening reports are used to aid in the determination of housing, bed, work, education and program assignments. The goal is to keep high risk for sexual abuse victims separated from those at high risk for being sexually abusive. All decisions concerning PREA are based on the individual and what is the best course of action for their incarceration period.

Documentation was provided regarding entries made by staff on changing a residents bed assignment due to reports of grooming by a PREA potential aggressor.

To date there have been no transgender or intersex residents, however there is discussion about procedurally what will be best practices if that type of resident is placed in the facility. The discussion included everything from housing to daily bathing expectations.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Residents can report sexual abuse or harassment in multiple different ways including verbally reporting to staff, anonymous notes, calling law enforcement and calling the PREA Coordinator's direct phone line. These same methods can be used to report retaliation or concern of staff neglect or violation of responsibilities contributing to the occurrence of such incidents.

There is no time limit on reporting PREA incidents through the grievance process. If allegations are made concerning a situation that occurred at a previous facility, policy states that the Facility Head shall follow the procedures for reporting.

All staff are considered mandatory reporters therefore policy states that any allegations be accepted and investigated whenever a report is made. If there is a concern, at shift change that information is verbally relayed to the oncoming shift. Staff can either call or email the PREA Coordinator or Facility Director, to make reports without following their chain of command in the event they are involved in the incident.

Staff interviews suggest that they understand their responsibilities as well as their rights concerning PREA. All were comfortable with reporting it to the Facility Director or the PREA Coordinator. Their belief is that any allegations reported will be properly investigated and addressed. They trust the process and the expectations.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Policy COR5.3-40 has a subsection on the Exhaustion of Administrative remedies. In it, is information regarding grievance rights for residents. There is no time limit on filing a grievance regarding allegations of sexual abuse. Any grievance that is not PREA related will follow regular VOA timelines for submission. Residents are not required to use the grievance process to report allegations of abuse nor must they attempt to resolve with staff. Grievances do not have to be submitted to a staff member who may be the focus of the allegation.

Third parties may file on behalf of a resident including fellow residents, staff, family, attorneys and outside advocates. If the resident declines having third-party assistance, it will be documented in writing.

Policy provides instructions on the handling of emergency grievances alleging substantial risk or imminent sexual abuse to be responded to within 48 hours. A final agency decision must be issued within 5 days.

Within 90 days of filing a PREA related grievance, a decision of merit must be made by the Agency. If an extension is needed before a decision can be made, the resident will be notified in writing with a definitive completion date.

The agency limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where it can be demonstrated that the resident filed in bad faith.

There have been no PREA related grievances filed in the last 12 months, emergency or otherwise.

Flyers with reporting information were hung in the common areas as well as the entrance/exit to the facility.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy states that resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services provided by the local hospital emergency room or rape crisis center. Information on these services can be found both on the PREA brochure as well as the flyers hung throughout the facility.

The agency has attempted to enter into an MOU with both the hospital and the rape crisis center however neither would sign them as presented. The Facility Director is working with both agencies in the hopes of creating a document that will meet the need for everyone involved. There is written confirmation of the attempts to secure the MOU's.

Interviews with residents confirmed that they are aware that outside agencies can provide services following a PREA related incident. Most of them couldn't provide specific information not because it wasn't available but because they weren't concerned for their safety. They did know where to find the information in the event it was needed.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Volunteers of America website has a Community Corrections tab that provides information about different facilities and their specific mission. There is information on the types of acceditations each facility has, if applicable, and programming offered. There is a PREA policy statement in regards to the zero tolerance and how to report allegations of sexual misconduct. It provides both the phone number and email address of the PREA Coordinator.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Staff are required to report any knowledge, suspiscion or information regarding an incident of sexual abuse or sexual harassment to the Facility Director immediately. This includes retaliation against staff or residents for prior reports and staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. After reporting to designated supervisors or officials, staff shall not reveal any information related to the abuse report to anyone other than the extent necessary for treatment, investigation and other security and management decisions.

Staff were able to confirm during interviews that they have a duty to report no matter how insignificant the information may seem or

regardless of whom made the allegation. They were also able to verbalize the need to only share information with specific persons involved in the case.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy states that when any staff learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

There have been no reports of imminent danger of sexual abuse in the past 12 months.

Staff were able to provide a scenario during the interviews of how they would respond if notified of the potential for imminent danger. They knew the chain of command, the required reporting documentation and the need to protect the victim from the perpetrator if housed in the same area.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Agency policy states that within 72 hours of being notified of allegations of sexual abuse from a previous incarceration at another facility, that the Facility Director or designee shall notify the head of that facility. If this takes place it will be documented. It is also understood that if allegations are made from a previous resident to a new facility, that upon notification, the investigation process will occur.

There have been no sexual abuse allegations made on a previous facility in the last 12 months nor have there been any regarding this facility with a previous resident.

The Facility Director was able to relay his responsibilities concerning allegations involving other facilities. While he is aware that there is a 72 hour window, he states it would be addressed as soon as possible once notification has been made.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy states that upon learning of an allegation of sexual abuse, staff first responders duties include:
*separation of victim and abuser;
*preservation and protection of crime scene until evidence can be collected; and,
*collection of physical evidence if within the time allotted so as to not destroy (including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating).

Agency policy states that if the first staff responder is not a security staff member, that they are required to request that the alleged victim not take actions that could destroy physical evidence and notify security staff.

There have been no sexual abuse allegations in the past 12 months. Both security staff as well as treatment staff understood first responders duties and the reasons for them.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The institutional plan for PREA outlines the coordinated actions in response to an incident for first responders, facility leaders as well as investigators.

Interviews of custody staff, treatment staff, facility director as well as PREA coordinator all confirm the agreement of the institutional plan.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable as there has been no new/renewed bargaining agreements since 8/20/12.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There are multiple protection measures in place to protect both staff and residents from retaliation. This includes housing changes or transfers of victims or abusers, removal of alleged staff or resident abusers from contact with victim and emotional support services for residents or staff that fear retaliation for reporting and cooperating with investigations. There is a designated Facility Director of Operations whose purpose is the monitor for possible retaliation.

For a period of 90 days following a report, the agency monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse. Any reports of retaliation will be remedied promptly. If there is a need to monitor for a period longer than 90 days, it will continue. In the interim, the Facility Director's obligation to monitor shall terminate if the agency determines the allegation is unfounded.

There are different ways that the monitoring can be accomplished including excessive disciplinary reports, housing or program changes, negative performance reviews or reassginments of staff.

There have been no reports of sexual abuse allegations or retaliation in the last 12 months.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy states that all substantiated allegations of conduct that appear criminal are referred for prosecution automatically as these are investigated by law enforcement.

There have been no substantiated allegations of sexual abuse in the past 12 months. If in the event there were, the agency would retain all written reports for as long as the alleged abused is incarcerated or employed by the agency plus 5 years.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy specifically states that Volunteers of America shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Hope Hall has a duty to report, to the resident, either verbally or in writing as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. If the investigation is conducted by an outside agency, Hope Hall will request relevant information so as to keep the resident informed of the investigation progress.

There has been one administrative investigation in the past 12 months that has documented proof of the residents notification. The investigation was unfounded as the resident didn't perceive it as a PREA incident. The staff involved was addressed and will receive training to address the deficiency. There have been no criminal investigations conducted by an outside agency in the past 12 months.

If there is substantiated abuse by a staff member towards a resident, they shall be notified of the outcomes of the investigation including how there employment is to be addressed if not terminated. This may mean no longer being posted within the residents unit, no longer employed at that specific facility, indicted by the authorities as well as conviction. The same shall go for a resident who is the aggressor. The outcomes of their investigation shall be reported to the victim as well.

There have been neither substantiated or unsubstantiated complaints within the past 12 months.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA policy specifically states that staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Disciplinary sanctions for violations relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff members' disciplinary history and the sanctions imposed for comparable offenses by other staff with similar histories.

There have been no violations or discipline due to this policy in the last 12 months. No one has been terminated or referred to law enforcement for prosecution due to sexual abuse within the last year either.

Interviews with both the Facility Director and the PREA Coordinator supported that the written policy is the standard to which disciplinary action is to follow. Both were able to verbalize the sequence of events up to and including termination as well as reporting to law enforcement for the filing of potential charges.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy COR 5.3-40 states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Consideration is taken as to whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policy by contractors or volunteers.

Signed copies of training provided for contractors and volunteers was provided along with the training curriculum.

There have been no reports of sexual abuse from contractors or volunteers within the past 12 months.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative and/or criminal finding that a resident engaged in resident-on-resident sexual abuse. The agency prohibits all sexual activity between residents, however

such activity is deemed sexual abuse only if it is the product of coercion.

Hope Hall doesn't offer therapy, counseling or other interventions designed to address and correct the underlying reasons or motivations for abuse. Treatment must be sought in the community.

There have been no resident-on-resident sexual abuse administrative or criminal findings in the last 12 months.

Residents are only disciplined for sexual conduct with staff upon finding out that the staff member didn't consent to contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, regardless of whether the investigaton is substantiated or not.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

It is the policy that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment, contraception, sexually transmitted infection testing and crisis intervention services. The nature and scope of services are determined by medical and mental health practitioners according to their professional judgement. These services are provided by Community Partners as Hope Hall doesn't employ these positions.

Interviews with both staff and residents confirmed that the expectation is that access to medical and mental health services is non-negotiable and will be done in a timely fashion following an occurrence.

Interviews with staff of Deaconess Hospital and Albion Fellows Bacon Center confirmed that there are plans in place as to how treatment is to be administered following an allegation of sexual abuse. There services are provided to the victim without financial cost and whether or not a perpetrator is named or if the victim cooperates with the investigation.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Medical and mental health evaluations and treatment if recommended are provided to all residents who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility. Pregnancy tests are offered to female victims of sexually abusive vaginal penetration while incarcerated. If in the event the female resident is pregnant, she will have access to timely and comprehensive information about lawful pregnancy-related medical services. Sexually Transmitted infection testing is provided regadless of gender. Within 60 days of

learning of abuse history, mental health treatment will be offered when deemed appropriate for all known resident-on-resident abusers.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

It is the practice of Hope Hall to conduct a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. Within 30 days of the conclusion of the criminal or administrative abuse investigation, there is a sexual abuse incident review. The review team includes upper-level management and allows for input from line supervisors, investigators and medical or mental health practitioners.

A report of the findings is completed with recommendations for improvement and it is submitted to the facility head and PREA Coordinator. The recommendations are implemented unless there are reasons for not doing so, and that information is documented.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Volunteers of America collects accurate, uniform data for every allegation of sexual abuse under its direct control using a standardized instrument and set of definitions at least annually. At a minimum, the standardized instrument includes data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files and sexual abuse incident reviews.

The agency doesn't contract with any private facilities therefore this portion of the standard is non-applicable.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Volunteers of America reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies and training including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

The annual report includes a comparison of the current year's data and corrective actions with those from prior years. It also provides and assessment of the agencys progress in addressing sexual abuse. All of this information is approved by the agency head and can be found on the VOAIN.org website.

Policy states that specific material from the reports will be redacted when publication would present a clear and specific threat to the safety and security of the facility, but must indicate the nature of the material redacted.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Incident based and aggregate data are securely retained but is readily available to the public at least annually through its website. All personal identifiers are removed prior to making aggregated sexual abuse data publicly available. All data collected is retained for at least 10 years after the date of the initial collection, unless federal, state, or local law requires otherwise.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Bridgette M. Collins 6/9/16

Auditor Signature Date